STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. BUILDING -- B. WING	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VERMILLION CONVALESCENT CENTER	1705 S MAIN ST CLINTON, IN 47842

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/08/24 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 At this Emergency Preparedness survey, Vermillion Convalescent Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 79. Quality Review completed on 08/09/24	E 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the providers allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Gum	RN, HFA/Administrator	08/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey Date: 08/08/24 Facility Number: 000052 Provider Number: 155124 AIM Number: 100290340 At this Life Safety Code survey, Vermillion Convalescent Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in resident sleeping rooms. The facility has a capacity of 100 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has one detached garage used for maintenance and equipment storage which was not sprinklered. Quality Review completed on 08/09/24		alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the providers allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the			

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	approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas such as a storage rooms was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the storage room next to the Expression's Hall entrance. Findings include: Based on observation with the Maintenance	K 0321	K321 Hazardous Area – Enclosure All Residents have the potential to be affected by this deficient practice No Residents were directly affected as a result this deficient practice The door closure was repaired on 8/9/2024. The door closure worked appropriately and the door closed	08/20/2024

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	Director during a tour of the facility at 12:22 p.m. on 08/08/24, the corridor door to the Storage room next to the entrance to Expression's Hall was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Maintenance Director and Assistant Administrator at the exit conference. 3.1-19(b)		latching into the door frame. ="" p=""> All doors equipped with an automatic door closure will be tested monthly in conjunction with the facilities established preventative maintenance schedule. Any door that is identified during these monthly tests not latching within the door frame will be adjusted and/or replaced immediately until the door is latching within the door frame. Results of these inspections will be turned into the monthly Quality Assurance Committee Meetings for review. These inspections will be on-going.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor			

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	covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 1 residents. Findings include: Based on observation with the Maintenance Director on 08/08/24 at 1:03 p.m. during a tour of the facility, the corridor door to Resident Room 411 had an impediment to closing, in that it took considerable force to close and latch into it's frame. Based on interview at the time of observation, the Maintenance Director confirmed the resident room door took considerable force to	K 0363	K363 Corridor – Doors All Residents have the potential to be affected by this deficient practice No Residents were directly affected as a result of this deficient practice The corridor door to room 411 was repaired on 8/9/2024 by the maintenance director allowing the door to open, close and latch into the door frame without having to use considerable force to latch the	08/20/2024

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	close and stated it's probably swollen and he would work on the door. This finding was reviewed with the Maintenance Director and Assistanct Administrator at the exit conference. 3.1-19(b)		door. All corridor doors will be inspected and tested monthly to ensure the door latches into the door frame in conjunction with the facilities established preventative maintenance schedule. Any door identified to be latching into the door frame using considerable force will be repaired immediately. Findings from these inspections will be turned into the Quality Assurance Committee for review. These inspections will be on-going.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC	K 0374	K374 Subdivision of Building Spaces – Smoke Barrier All Residents have the potential to be affected by this deficient	08/20/2024

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	8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff and up to 20 residents near the Expressions smoke barrier doors. Findings include: During a tour of the facility with the Maintenance Director on 08/08/24 at 12:25 p.m., the set of smoke barrier doors between the front south corridor and the Expressions wing failed to close tight. When tested, the doors hung-up on the coordinating device leaving a 4-inch gap between door leaves. Based on interview during the time of observation, the Maintenance Director agreed the smoke barrier doors did not close completely due to malfunction of the coordinating device. This finding was reviewed with the Maintenance Director and Assistant Administrator at the exit conference. 3.1-19(b)		practice No Residents were directly affected as a result of this deficient practice The door coordinating device that malfunctioned was repaired on 8/9/24 by the maintenance director allowing the smoke barriers to close appropriately. All smoke and fire doors will be tested monthly during the monthly facility fire drill in conjunction with the established facility fire drill schedule. Should any door not close appropriately, corrections will be made immediately and if needed the door coordinating device will be replaced. These monthly fire drill reports and inspections will be submitted to the monthly Quality Assurance Committee for review. These inspections will be on-going.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all restrooms were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires	K 0511	=”” p=””>K511 Utilities – Gas and Electric All Residents have the potential to	08/20/2024

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	utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater		be affected by this deficient practice No Residents were directly affected as a result of this deficient practice The GFCI located across the corridor from the north shower was replaced with a new GFCI on 8/9/2024. Once installed the GFCI was tested and functioned appropriately when tested. All GFCI outlets will be tested weekly for 30-days, bi-weekly for 30-days, monthly thereafter for 6 months to ensure they test appropriately. GFCI outlets will then be tested annually in conjunction with the established facility preventative maintenance schedule. These audit logs will be submitted to the facility Quality Assurance Committee for review. Any deficient practice identified during these inspections will be corrected immediately.	

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	hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 residents, staff, and visitors in the vicinity of the restrooms by the north shower. Findings include: Based on observation with the Maintenance Director during a tour of the facility on 08/08/24 at 1:00 p.m., there was one electric receptacle within three feet of the sink in a restroom across the corridor from the north shower. The electric receptacle was provided with a ground fault circuit interrupter (GFCI), but it failed to function properly when tested. The GFCI outlet would not trip when tested multiple times with a GFCI tester. Based on interview at the time of observation the Maintenance Director confirmed the GFCI receptacle would not trip when tested. This finding was reviewed with the Maintenance			

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	Director and Assistant Administrator at the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liquid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 2 of over 50 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 3 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 1:30 p.m. on 08/08/24, one liquid oxygen	K 0930	Oxygen containers in room 239 and 402 are not stored; rather, are in use for these two residents. Doors to room 239 and 492 are fire rated doors with a rating of 90 minutes. A house-wide inspection identified no other concerns regarding liquid oxygen use. In an effort to ensure ongoing compliance, the Maintenance Director, Respiratory therapists and Administrator were educated and remain aware of the requirements for liquid oxygen storage and use. As a means of quality assurance, the Regional Director shall conduct facility wide rounds during at least monthly inspections for a minimum of six months to confirm continued compliance with requirements for liquid oxygen storage and use.	08/20/2024

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	container was stored in resident sleeping Room 239, and in resident sleeping Room 402. Each of the two resident sleeping rooms were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the rooms were not self-closing or automatic closing and were not equipped with a minimum 45-minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Director agreed a liquid oxygen container was stored in each of the two resident sleeping rooms and the rooms were not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Maintenance Director and Assistant Administrator during the exit conference.			